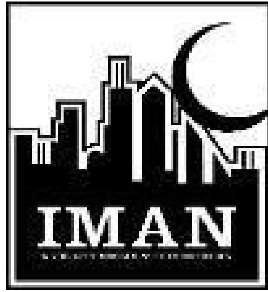

Inner-City Muslim Action Network-Atlanta

Green ReEntry Program Application

IMAN's **Green ReEntry** program assists formerly incarcerated men and women by providing support in a number of areas to reduce recidivism by helping individuals become successfully re-acclimated to the community. The twelve-week program offers a holistic approach to helping participants meet these goals by offering individualized services that may include: transitional housing, life skills training, case management, family and individual counseling, as well as a stipend-based job training program that prepares participants for careers as HVAC technicians, construction managers, carpenters, residential electricians and masons. The program consists of both academic classes and hands-on training, provided in a group atmosphere that encourages personal development and independence. For this period we are only offering Training in Plumbing and Project Management.

Application Deadline- August 11, 2017

For more information, please contact:

Najee Shareef
Green ReEntry Manager
404-969-8605
E: Shareef@imancentral.org
W: www.imancentral.org/Atlanta

(Rev.12/2016)

Pre-Screening Requirements

Placement in the **Green ReEntry** program depends on the applicant's needs, IMAN's ability to service the prospective participant, and available space. The program is split into several phases: (1) application; (2) participant screening; (3) interview; (4) program acceptance/participation; (5) graduation; and (6) post-program follow-up.

Applicants can apply by requesting an application via:

A. The Field Service department within the correctional institution (2-4 mouth prior to release)
B. U.S. Postal service (2-4 month prior to release)
C. Visiting our office
D. Contacting the **Green ReEntry** Manager

Additional requirements (may vary per applicant):

A. Complete Application
B. Complete psychological evaluation (with our on-site Behavioral Health Manager)
C. Complete physical (with our on-site medical staff)
D. Current or anticipated supervision from a state agency (such as IDOC, DCFS, etc.)

The following information is requested from clinical and field services for a needs-assessment:

A. PRB Orders
B. Psychological and Psychiatric report
C. Copy of Disciplinary Record
D. Two (2) Passport-size photographs
E. IDOC authorization of release of medical, mental health and substance abuse records
F. Present Medical and Mental health report

The Green ReEntry Program will not be able to accommodate some services based on our abilities or at our discretion, per programmatic stipulations. The Green ReEntry Program reserves the right to refuse or discontinue service to any applicant or referring agency that <u>may</u> include participants belonging to any of the following categories:

A. Interstate transfers or out-of-state parole request
B. Georgia Sex Offender registry (GSORT)
C. Offenses against youth or those required to register with Georgia Violence Against Youth Registry

D. Department of Juvenile Justice (DJJ)
E. Persons with severe medical, mental health and/or physical disabilities where physical aides, handicap-accessible facilities and hospital equipment is needed (i.e. seizures, epilepsy, heart conditions, degenerative ailments or long-term care treatments)
F. Present or previous Orders of Protection
G. In-patient treatment or substance abuse detoxification prescriptions
H. Pyromania or arson conviction

*(Please contact the **Green ReEntry** Manager to discuss your eligibility should you fall into one of these categories.)*

IMAN Green ReEntry Program Application

Date: / /

If you need more space than what is provided, please use the back of the page.

Name: ____

Alias(es): ____

IDOC or CCDOC Number: ______________________________

Address: ____

Phone Number: ____________________________________

Email Address: ____________________________________

Social Security Number: - -

Date of Birth: / /

Number of children:

Current Marital Status: *Single* *Married* *Divorced* *Separated* *Widowed*

Race: *Black* *White* *Hispanic/Latino* *Asian* *Middle Eastern/Arab* *Other:* __________

Current Institution: ______________________________________

Offense/Conviction(s): ____________________________________

Sentence (in months): Date sentenced: / /

Actual time served (in months): Scheduled parole date: / /

Prior to this current or most recent detention/incarceration, were you ever incarcerated as an adult? Yes No

If YES, please provide committing offense(s) and the year (s) of incarceration (ie. 2002-2005):

Offense(s): ______________________________ Year(s) Incarcerated: ______________

Offense(s): ______________________________ Year(s) Incarcerated: ______________

Offense(s): ______________________________ Year(s) Incarcerated: ______________

**If you have any sex offense convictions, please utilize this space provide details:*

____

____

MEDICAL INFORMATION

Please list any medical conditions or disabilities you currently have:

Arthritis	Glaucoma	Liver Disease
Asthma	High Blood Pressure	Osteoporosis
Bleeding problems	High Cholesterol	Seizures
Breathing difficulty	Hearing impairment	Stroke
Cancer	Heart Problems	Thyroid Problem
Diabetes	Joint Replacement	Ulcers
Emphysema	Kidney Disease	Visual Impairment

Other: ____

Please list any past or current medications taken for any of the above medical conditions: ________________

____

____

Have you ever been hospitalized for a medical emergency/condition? Yes No

If yes, please list reason(s) for admission(s) and year(s) admitted: ______________________________

____

____

MENTAL HEALTH

Have you ever been diagnosed with any of the following mental health disorders?

☐ Anxiety disorder (such as acute stress, panic, agoraphobia, obsessive-compulsive, PTSD, general anxiety)

☐ Eating disorder (such as anorexia, bulimia)

☐ Mood disorder (such as depression, bipolar)

☐ Personality disorder (such as paranoid, schizoid, antisocial, borderline personality)

☐ Schizophrenia or another psychotic disorder (such as delusional disorder, schizoaffective disorder)

☐ Other: ____

Please list any past or current medications taken for any of the above mental health disorders. *Please list reason(s) for medication(s), dosage(s), duration and prescribing physician:*

____

____

Have you ever been admitted to a psychiatric hospital/residence?

Yes No*If yes, please list reason(s) for admission(s) and year(s) admitted:*

____

____

Have you ever attempted suicide or had suicidal thoughts?
Yes No *If yes, please list reason(s) and year(s):*

____

____

Please list any past/present experiences with physical, emotional or sexual abuse:

____

____

Did you ever attend or receive certification for participating in substance abuse or anger management classes?
Yes No *If yes, please list agency and year(s):*

____

____

How important is it for you to receive counseling services for mental health or substance abuse needs?

Not at all *Slightly* *Moderately* *Considerably* *Extremely*

SUBSTANCE USE

Of the following drugs, which one do you have the most serious problem with? *Check one.*

	Yes	No
None		
Alcohol		
Marijuana/Hashish		
Hallucinogens/LSD/PCP/Psychedelics/Mushrooms		
Inhalants		
Crack/Freebase		
Heroin and Cocaine (mixed together as speedball)		

Cocaine (by itself)		
Heroin (by itself)		
Street Methadone (non-prescription)		
Other Opiates/Opium/Morphine/Demerol		
Methamphetamines		
Amphetamines		
Tranquilizers/Barbiturates/Sedatives (downers)		

How serious do <u>you</u> think your drug problem is?

Not at all *Slightly* *Moderately* *Considerably* *Extremely*

How often did you use each type of drug during the <u>last 12 months</u> before being detained/incarcerated?

	No use at all	Only a few times	Monthly	Weekly	Daily
Alcohol					
Marijuana/Hashish					
Hallucinogens/LSD/PCP/Psychedelics /Mushrooms					
Inhalants					
Crack/Freebase					
Heroin and Cocaine (mixed together as speedball)					
Cocaine (by itself)					
Heroin (by itself)					
Street Methadone (non-prescription)					
Other Opiates/Opium/Morphine/Demerol					
Methamphetamines					
	No use at all	Only a few times	Monthly	Weekly	Daily
Amphetamines					
Tranquilizers/Barbiturates/Sedatives (downers)					
Other *(specify):*					

How many times <u>before now</u> have you ever been in an <u>inpatient</u> drug treatment program?

Never *1 time* *2 times* *3 times* *4 or more times*

How many times before now have you ever been in an outpatient drug treatment program? [*Not including AA/NA/CA meetings.]* *Never* *1 time* *2 times* *3 times* *4 or more time*

How important is it for you to get drug treatment now?

Not at all *Slightly* *Moderately* *Considerably* *Extremely*

EDUCATION

Please check your highest level of education completed:

☐ No schooling completed
☐ Completed elementary school (Grades K through 8)
☐ Completed some high school, but did not obtain my GED
☐ Completed some high school and obtained my GED
☐ High school graduate (diploma)
☐ Correspondence/Online high school degree
☐ Completed some college/vocational schooling, but did not receive a diploma or certificate.
☐ Diploma or certificate from a junior college/community college/trade school/vocational school
☐ Correspondence bachelor's degree
☐ Bachelor's degree from a four-year college (e.g., B.A/B.S/LL.B)
☐ Completed some graduate or professional schooling
☐ Graduate or Professional degree (e.g., M.A/M.S/M.D./PhD)

During this detention/incarceration, did you attend school?

No Yes *If yes, what classes were you enrolled in?* ____

____

During this detention/incarceration, did you get a degree or certificate?

No Yes *If yes, what degree or certificate did you obtain?* _______________________________________

____

Are you thinking about going back to school or attending a trade/vocational school after your release?

No Yes *If yes, please explain further:* ____

-

EMPLOYMENT

Have you ever held a job for longer than one year?

- No Yes *If yes, what did you do?* ____

-

What was your most recent job prior to incarceration? ____

Is there any reason why you may be unable to work after release from this incarceration?

- No Yes *If yes, why?* ____
-

Please list your employment/trade skills:

____

____

____

PERSONAL ASPIRATIONS

Upon release from jail/prison, please describe the top three personal goals you hope to accomplish:

1. ____

2. ____

3. ____

What would motivate you to accomplish your goals?

____

____

Do you have a social support network? If so, who are those individuals?

____

____

Please list and describe three personal strengths:

1. ____

2. ____

3. ____

Please list and describe three personal weaknesses/areas of improvement:

1. ____

2. ____

3. ____

Prior to this detention/imprisonment, please describe life circumstances that may have contributed to your incarceration:

____
____
____
____
____

Please describe what you like most about yourself:

____
____

What would you like to most change/improve about yourself:

____
____

CONTACT INFORMATION

Please list significant persons in your life who you trust and provide their addresses and phone numbers. (This information is needed in case of emergency.)

1. ____

2. ____

Of the following programs offered by the **Green ReEntry** program, please check all needs that apply to you:

☐ Educational support
  ☐ Employment services
☐ Housing services
☐ Parenting classes
☐ Family counseling
  ☐ Carpentry
  ☐ Electrical
  ☐ Weatherization

☐ Individual counseling
  ☐ Anger management
☐ Substance abuse treatment
☐ Life skills (financial planning, etc.)
☐ Medical Care
  ☐ Plumbing
  ☐ HVAC
  ☐ Energy Auditing

In order of importance, please list your top four service needs *(number one being the <u>most</u> important, four being less important):*

1. ____

2. ____

3. ____

4. ____

Please utilize address/add any information you feel will be beneficial as we review your appliction:

____

____

____

____

____

____

____

____

Consent for Disclosure of Confidential Information

*Applicant: If agreed, sign the two enclosed consent forms and submit with your application to the **Green ReEntry** program.*

FIELD SERVICES OR REFERRING AGENCIES: Please sign the witness sections of this form and send the information request below along with the application form completed by the undersigned to:
Inner –City Muslim Action Network
Atlanta , Georgia 30032

I authorize disclosure by ____ (name of referring agency) and/or their agents of my file information and records to the extent necessary to be sent to: Inner City Muslim Action Network to make an adequate plan for my participation in the **Green ReEntry** program. I understand that such information will be treated according to the Unified Code of Corrections, Chapter 38, 1003-5-1 (b), and Administrative Regulations 844 and 846 (if applicable) and all other state and federal law regarding the release of confidential records. I also understand that I may withdrawal this consent at any time, and that in granting this consent, disclosure shall be limited to the professional personnel having responsibility with respect to my involvement in the program at Inner-City Muslim Action Network. The following records may be disclosed for the purpose described above (*where applicable*):

A. PRB Orders
B. Psychological and Psychiatric Reports
C. Copy of Disciplinary Record
D. Two (2) Passport-sized Photographs (if possible)
E. IDOC Authorization of release of medical, mental health, & substances abuse records
F. Parole/MSR agreement
G. Reporting Instructions
H. Present medical and mental health status report
I. Parole/MSR agreement
J. Reporting Instructions
K. Health Status Report
L. Face Sheet Leaflet

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION TO THE Georgia DEPARTMENT OF CORRECTIONS OR REFERRING AGENCY (____): I consent to the release of records and information pertaining to my participation in medical treatment, drug abuse services, mental health counseling, psychiatric treatment, case management, or other such services to the Georgia Department of Corrections, the Parole and Pardon Board, and their agents including Adult Parole Services, and/or to above-named referring agency.

Printed Name of Applicant: ____

Signature of Applicant: ____ Date: ____________________

Printed Witness Name: ____

Signature of Witness: ____ Date: ____________________

Georgia Department of Corrections

Authorization for Release of Offender Medical Health Information

This Authorization may not be used for mental health or substance abuse treatment information (use form DOC 0240)

The Department of Corrections will not condition treatment on this authorization. If authorizing disclosure to persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information. However, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization.

I hereby authorize____ to release the following
(Facility)
information: (state specific medical health information to be disclosed including date(s) or date range):

PRESENT DIAGNOSES, INITIAL EVALUATION REPORTS, TREATMENT PLANS, PROGRESS REPORTS, MEDICATION REGIMENS AND MANAGEMENT RECORDS, AND CONTINUING CARE PLAN (IF APPLICABLE)

At Request of Offender and/or: Inner-City Muslim Action Network from the records of:

______________________	______________________
(ID#)	(Print Offender's name)

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility ☑ Other: Inner-City Muslim Action Network

Name: Inner-City Muslim Action Network
(Print Name)

Address: 2744 West 63rd St. Chicago IL 60629

I hereby release and hold harmless, the State of Georgia, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. Records disclosed may contain confidential medical information including HIV disease information. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the prison Facility Privacy Officer.

Expiration: This authorization will expire (complete one):

☑ 45 days from date of signature

☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):

____

Signature:

______________________	SELF	______________
Signature of Offender or Person Authorized to Consent	Relationship	Date

______________________	______________________	______________
Witness Printed Name	Title	Date

____
Witness Signature

Give Offender a copy if DOC made the request for release

Distribution: Offender's Medical File DOC 0241 (Rev.01/2005)

Street Address: City: State: Zip Code:

Georgia Department of Corrections

Authorization for Release of Offender Mental Health or Substance Abuse Treatment Information

This Authorization may not be used for medical health information (use form DOC 0241)

The Department of Corrections will not condition treatment on this authorization. Mental health information disclosed pursuant to the authorization may not be further disclosed except pursuant to authorization from the offender or offender's representative. If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information.

I hereby authorize____ to release:
(Facility)

Section A: Mental Health Information (state specific mental health information to be disclosed including date(s) or date range):
PRESENT DIAGNOSES, INITIAL EVALUATION REPORTS, TREATMENT PLANS, PROGRESS REPORTS, MEDICATION REGIMENS AND MANAGEMENT RECORDS, AND CONTINUING CARE PLAN (IF APPLICABLE)

Section B: Substance Abuse Treatment Information (as indicated below):
If Substance Abuse Treatment records are being authorized, initial all relevant areas below (including date(s) or date range):

☑ Diagnoses ________________________
☑ Toxicological Reports/Drug Screens ________________________
☑ Evaluation/Assessment ________________________
☑ Medication Management Information ________________________
☑ Treatment Plan ________________________
☑ Attendance ________________________
☑ Summary of Treatment Services ______________________
☑ Treatment Progress Report ________________________
☑ Continuing Care Plan ________________________
☑ Educational Information ________________________
☑ Other (specify): _________

At Request of Offender and/or: Inner-City Muslim Action Network from the records of:

___________________________________ (ID#)

___________________________________ (Print Offender's name)

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility ☑ Other: Inner-City Muslim Action Network

Name: Inner-City Muslim Action Network- Atlanta ____________________________________
(Print Name)

Address:____

I hereby release and hold harmless, the State of Georgia, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the prison Facility Privacy Officer.

Expiration: This authorization will expire (complete one):

☑ 45 days from date of signature

☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):
____

Signature:

_______________________________	SELF	_______________
Signature of Offender or Person Authorized to Consent	Relationship	Date
_______________________________	_______________________________	_______________
Witness Printed Name	Title	Date
_______________________________		
Witness Signature		

Give Offender a copy if DOC made the request for release

Distribution: Offender's Medical File

DOC 0240 (Rev.01/2005)